STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366044	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Paulding The	199 County Road 103 Paulding, OH 45879

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of the facility submitted Self-Reported Incident (SRI), review of the facility investigation, and review of facility policy, the facility failed to ensure a complete and thorough investigation of alleged resident abuse. This affected one (#17) of four residents reviewed for abuse. The facility census was 39. Findings include:Review of Resident #17's medical record revealed an admission date of 07/30/25. Diagnoses included depression, paroxysmal atrial fibrillation, aneurysm of artery of lower extremity, hypothyroidism, and anxiety disorder. Review of Resident #17's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition. Review of Resident #17's care plan dated 07/30/25 revealed Resident #17 had an alteration in skin related to an abscess to her right groin with interventions to administer medications as ordered, administer treatments as ordered, and monitor for effectiveness. Interview on 09/08/25 at 3:46 P.M. with Resident #17 revealed on 08/22/25 she was struck by Licensed Practical Nurse (LPN) #234 on her hand after attempting to hold her abdominal fold up for LPN #234 to have easier access to complete wound care. Resident #17 stated she reported the incident to the administrator the next day (08/23/25). Interview on 09/09/25 at 8:15 A.M. with Resident #16 revealed on 08/22/25 she heard her roommate (Resident #17) be struck by LPN #234 from behind the privacy curtain. Resident #16 stated LPN #234 yelled don't touch that. Interview on 09/09/25 at 10:10 A.M. with Resident #17 revealed she considered the incident to be abuse. Resident #17 stated sometimes she felt safe with LPN #234 and sometimes she did not. Resident #17 stated if her roommate was in the room, she had a witness of how she was treated by LPN #234. Review of Resident #17's medical record revealed an admission date of 07/30/25. Diagnoses included depression, paroxysmal atrial fibrillation, aneurysm of artery of lower extremity, hypothyroidism, and anxiety disorder. Review of Resident #17's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition.Review of Resident #17's care plan dated 07/30/25 revealed Resident #17 had an alteration in skin related to an abscess to her right groin with interventions to administer medications as ordered, administer treatments as ordered, and monitor for effectiveness.Interview on 09/08/25 at 3:46 P.M. with Resident #17 revealed on 08/22/25 Licensed Practical Nurse (LPN) #234 slapped her on her hand after attempting to hold her abdominal fold up for LPN #234 to have easier access to complete wound care. Resident #17 stated she reported the incident to the administrator the next day (08/23/25). Interview on 09/09/25 at 8:15 A.M. with Resident #16 revealed revealed the resident was cognitively intact. Further interview revealed that on 08/22/25 she heard LPN #234 slap her roommate (Resident #17). The privacy curtain was pulled, so she did not visually see what occurred. Resident #16 stated LPN #234 stated don't touch that. Interview on 09/09/25 at 1:51 P.M. with LPN #234 revealed she denied slapping Resident #17. Interview on 09/09/25 at 3:59 P.M. with the Administrator and Assistant Director of Nursing (ADON) #204 revealed the facility submitted a Self-Reported Incident (SRI) related to Resident #17's allegation of abuse.Review of the SRI dated 08/24/25 revealed Resident #17 alleged LPN #234 slapped her hand during wound care and yelled don't touch that your' re going to get it infected. Resident #17 had no pain, discomfort, redness or discoloration to her hands. LPN #234 stated that during wound care, she thought the resident was going to touch the adhesive tape and she nudged her hand away from the area and told her not to touch it and then told the resident of potential for infection. LPN #234 denied slapping the resident. Review of the facility investigation revealed no evidence a witness statement was obtained from Resident #16, who was present in the room at the time of the incident. Additionally, the investigation did not include any staff statements. Interview on 09/11/25 at 8:56 A.M. with the Director of Nursing (DON) verified the facility did not get a witness statement from Resident #16 who was Resident #17's roommate and present in the room at the time of the incident and further confirmed no additional staff statements were obtained.Review of the undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property revealed the person investigating the incident should interview the resident, the accused, and all witnesses. Witnesses generally included anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident, and employees who worked closely with the accused employee and/or the alleged victim the day of the incident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident representative interview, medical record review, staff interview, and review of facility policy, the facility failed to ensure residents who were dependent for care received assistance with shaving. This affected one (#41) of two residents reviewed for activities of daily living (ADLs). The facility census was 39.Findings include:Review of the medical record revealed Resident #41 was admitted on [DATE] with diagnosis of early onset cerebellar ataxia, physical debility and vascular dementia.Review of the Minimum Data Set (MDS) assessment, dated 07/20/25, revealed Resident #41 was cognitively intact and required supervision/touching assistance with personal hygiene.Review of care plan dated 08/06/25 revealed Resident #41 had a ADLs self-care deficit. Interventions included supervision with personal hygiene.Review of the Certified Nursing Assistant (CNA) personal hygiene task charting for the past 30 days revealed Resident #41 was marked as dependent 18 times, marked as requiring substantial assistance three times, marked as requiring supervision or touching assistance eight times.Observation on 09/08/25 at 11:15 A.M. of Resident #41 revealed the resident appeared disheveled with an unkempt beard and mustache covering his top lip. Interview on 09/08/25 at 11:23 A.M. with Resident #41's responsible party revealed Resident #41 was not able to shave himself and he used to shave the resident in the past; however, the resident preferred the aides to do it. Observation on 09/09/25 at 11:02 A.M. of Resident #41 revealed their mustache was still long, unkempt and protruding over the resident's lips.Observation on 09/10/25 at 10:20 A.M. of Resident #41 revealed his mustache was still long, unkempt and protruding over his lips. Additional observation revealed food remnants located in the resident's mustache.Interview on 09/10/25 at 10:26 A.M. with Certified Nursing Assistant (CNA) #264 verified Resident #41's mustache was long and unkempt.Observation on 09/10/25 at 11:50 A.M. revealed Resident #41 was in the dining room after eating lunch. Resident #41 was observed to have his mustache dirty with food and covering his top lip. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, reviewed August 2021, revealed that appropriate care and services would be provided for residents who were unable to carry out ADLs independently including hygiene, bathing dressing grooming and oral care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure fall interventions were in place. This affected one (#10) of one residents reviewed for falls. The facility census was 39. Findings include:Review of the medical record revealed Resident #10 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, neuromuscular dysfunction of bladder, essential hypertension, Type II diabetes with diabetic polyneuropathy, major depressive disorder, and carpal tunnel syndrome.Review of the Minimum Data Set (MDS) assessment, dated 06/25/25, revealed Resident #10 was cognitively intact and had no falls since admission. Review of the care plan, updated 09/08/25, revealed Resident #10 was at risk for falls. Interventions included non-slip strips in front of the shower (initiated on 08/29/25). Review of the unwitnessed fall documentation, dated 08/29/25, revealed Resident #10 had slipped on a towel on the bathroom floor. The root cause was determined to be the resident slid on a wet towel when stepping out of the shower. The intervention included skid strips in front of the shower. Observation on 09/08/25 at 12:05 P.M. revealed Resident #10's bathroom flooring did not have non-skid strips outside of the shower. Interview on 09/08/25 at 12:13 P.M. with Licensed Practical Nurse (LPN) #246 verified there were no non-skid strips in Resident #10's bathroom outside of the shower. Review of the facility fall policy, reviewed April 2025, revealed staff would identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review, staff interview, and policy review, the facility failed to ensure recommended nutritional supplements were implemented. This affected one (#4) of three residents reviewed for nutrition. The facility census was 39. Findings include:Review of Resident #4's medical record revealed an admission date of 04/10/25. Diagnoses included dementia, muscle weakness, depression, altered mental status, and Type II diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/14/25, revealed Resident #4 had severe cognitive impairment. Review of the care plan, dated 04/10/25, revealed Resident #4 had a nutritional problem or was at risk for potential nutrition impairment/dehydration related to his diagnoses. Interventions in place included to provide and serve dietary supplements as ordered, monitor intake and record each meal, and a registered dietitian (RD) should evaluate and make diet change recommendations as needed. Review of a Nutritional Assessment, dated 07/15/25, revealed the RD recommended a trial of magic cup (nutritional supplement) with twice daily, with lunch and dinner for nutritional support.Review of Resident #4's physician orders for the month of July 2025 and August 2025 revealed no orders for a magic cup.Interview on 09/11/25 at 11:47 A.M. with RD #301 confirmed that on 07/15/25, a recommendation was made to trial a magic cup supplement with lunch and dinner for added nutrition support for Resident #4. Interview on 09/11/25 at 1:55 P.M. with the Director of Nursing (DON) verified RD #301's recommendation from 07/15/25 was not followed-up on and the magic cup nutritional supplement was not implemented for Resident #4. Review of the facility policy titled, Medical Nutrition Therapy Recommendations, undated, revealed medical nutrition therapy recommendations from the registered dietitian would be implemented, or the reason for non-implementation will be documented in a timely manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, review of facility policy, and review of the Food and Drug Administration (FDA) guidelines, the facility failed to label refrigerated foods and practice proper hand hygiene during food service. This had the potential to affect all residents. The facility census was 39. Findings include: 1. Observation on 09/08/25 at 8:20 A.M. of the walk-in refrigerator revealed the following food items not labeled or dated: a gallon size plastic bag of sliced cheddar cheese, bag of bologna, and container of coleslaw. Interview on 09/08/25 at 8:28 A.M. with Dietary Manager (DM) #217 verified the three food items in the walk-in refrigerator were unlabeled and undated.Review of the facility policy titled, Food Storage, dated 2023, revealed leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. 2. Observation on 09/10/25 at 10:40 A.M. revealed [NAME] #207 was pureeing the lunch meal. [NAME] #207 was observed to have fingernails painted with a thick layer of polish. While completing the task, [NAME] #207 was observed to wipe her hands on her pants twice and scratch her face after washing her hands. Interview on 09/10/25 at 10:50 A.M. with [NAME] #207 verified having nail polish on and touching her pants and face during the food service preparation. Review of the facility policy titled, General Hazard Analysis Critical Control Points Guidelines for Food Safety, dated 2023, revealed food and nutrition staff will be educated and monitored in hand washing.Review of the FDA Food Code Recommendations, dated 2022, revealed food employees, unless wearing intact gloves in good repair, may not wear fingernail polish or artificial fingernails when working with exposed food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure accurate resident medical records. This affected one (#10) of two residents residents reviewed for accurate medical records. The facility census was 39.Findings include: Review of the medical record revealed Resident #10 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, neuromuscular dysfunction of bladder, essential hypertension, Type II diabetes with diabetic polyneuropathy, major depressive disorder, and carpal tunnel syndrome. Review of the Minimum Data Set (MDS) assessment, dated 06/25/25, revealed the resident was cognitively intact. Review of a physician order, dated 11/13/24, revealed an order for insulin lispro subcutaneous solution pen-injector 100 unit/milliliters (ml), inject 10 units subcutaneously before meals related to Type II diabetes mellitus with diabetic polyneuropathy., hold if (blood sugar [BS]) was less than 150. Review of the Medication Administration Record (MAR) for June 2025 revealed twelve instances when Licensed Practical Nurse (LPN) #234 documented Resident #10's the insulin was administered when the BS was less than 150. Review of the MAR for July 2025 revealed twelve instances when LPN #234 documented Resident #10's insulin was administered when the BS was less than 150. Review of MAR for August 2025 revealed 15 instances when LPN #234 documented Resident #10's insulin was administered when the BS was less than 150. Review of MAR for September 2025 revealed five instances when LPN #234 documented Resident #10's insulin was administered when the BS was less than 150. Interview on 09/09/25 at 1:56 P.M. with LPN #234 verified an inaccurate medical record for Resident #10. LPN #234 stated she did not administer insulin as documented in the MAR, adding she was not familiar with how to documented the BS was outside of parameters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure appropriate Personal Protective Equipment (PPE) was donned prior to providing care for a resident who required Enhanced Barrier Precautions (EBP). This affected one (#17) of one resident reviewed for EBP. The facility census was 39. Findings include:Review of Resident #17's medical record revealed an admission date of 07/30/25. Diagnoses included depression, paroxysmal atrial fibrillation, aneurysm of artery of lower extremity, hypothyroidism, and anxiety disorder. Review of Resident #17's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition.Review of Resident #17's care plan dated 07/30/25 revealed Resident #17 had an alteration in skin related to an abscess to her right groin with interventions to administer medications as ordered, administer treatments as ordered, and monitor for effectiveness.Observation on 09/08/25 at 3:41 P.M. revealed Certified Nursing Assistant (CNA) #254 was assisting Resident #17 into her bed and into a comfortable position. CNA #254 did not don PPE prior to assisting Resident #17. Interview on 09/08/25 at 3:44 P.M. with CNA #254 verified she did not don PPE, including a gown and gloves, prior to providing direct contact care with Resident #17. CNA #254 stated if she were assisting with changing the wound dressing or proving care, she would wear PPE, but PPE was not needed just for assisting Resident #17 with a transfer into bed. Review of the facility policy titled, Enhanced Barrier Precautions (EBP), last revised in April of 2025, revealed EBP should be employed when transferring a resident. Review of the CDC guidance titled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms [MDROs]), dated 04/02/24 and located at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html#cdc_generic_section_2-enhanced-barrier-precautions-in-nursing-homes-video-posters-pocket-guide, revealed the use of gown and gloves for high-contact resident care activities was indicated for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Examples of high-contact resident care activities requiring gown and glove use for EBP included, but not limited to, dressing, bathing/showering, transferring, providing hygiene, and providing wound care.